Michigan Department of Community Health Bureau of Health Systems, Division of Operations, Complaint Intake P.O. Box 30664, Lansing, MI 48909 Fax Number (517) 241-0093 **Complaint Hotline: 1-800-882-6006**	**FACILITY INCIDENT REPORT** Authority: MCL 333.21771 Completion of this form is governed by MCL 333.21771 concerning notification requirements.

INSTRUCTIONS: Complete this form and return by fax and/or mail within 24 hours of a determination that there is cause to believe that a resident was physically, mentally or emotionally abused, mistreated, or harmfully neglected.
Notice: This form is **in addition to required telephone notification** to the Complaint Hotline.
For assistance, please call the Complaint Intake Unit at (517) 241-4712.

FACILITY INFORMATION

Facility Name:	
Address:	Administrator/Contact Name:
City, State, Zip:	Daytime Telephone Number: ( )

RESIDENT INFORMATION (if resident involved)

Name:	Date of Birth: (Mo./Day/Yr.)
Last Known Address: (including room number)	Daytime Telephone Number: ( )

If resident has been adjudicated incompetent or is under age 18: name, address, and telephone number of parent, guardian, or legal representative.

Was the resident injured in the incident? No Yes If YES, what was the injury?

Is the resident able to give a statement? No Yes	What is the resident's current status?

SUMMARY OF INCIDENT (Attach additional sheets if necessary. No. of pages attached ____)

Please describe what occurred in detail: (Note: Facility investigation summary to be entered on reverse side.)

Who was involved? (names of residents, staff person and titles, etc.)

When did it occur? Date: _____ Time: _____ AM PM	Date/Time Discovered or Reported? Date: _____ Time: _____ AM PM

Where did the incident occur? (for example, in the hallway between Room 105 and 107)

(over →)

SUMMARY OF INCIDENT-CONTINUED

How did you become aware of the incident?

Who else has information about this alleged incident? (Include name and work titles.)

Are there related documents/ information such as photos, tapes, medical records, etc?
No Yes If YES, please describe:

INFORMATION ABOUT ALLEGED PERPETRATOR/INVOLVED STAFF PERSON (IF APPLICABLE)

Name:	Driver's License (if known):	Social Security Number (if known):	Date of Birth: (Mo./Day/Yr.)
Position/Title (at time of incident):		Daytime Telephone Number and Hours Available: ( )	
Last Known Mailing Address:		Michigan Nurse Aide Registry Number: (if applicable):	

AGENCY/LAW ENFORCEMENT INVOLVEMENT

Check if the Attorney General, the police, or any other agency was contacted about this matter.
Attach a copy of any agency/law enforcement incident report available.

Agency/Police Precinct Number: (City/Town)	Case Number (if known)
Contact Person:	Telephone Number ( )

SUMMARIZE FACILITY INVESTIGATION BELOW
(Attach additional sheets if necessary. No. of pages attached ____)

Action taken by facility: (Additional training for staff person, termination, counseling memo, etc.)
(Attach additional sheets if necessary. No. of pages attached ___)

PERSON PREPARING THIS REPORT

I hereby attest that the information provided above is true to the best of my personal knowledge.

Name:	Position or Title:	Business Address:	
Signature:		Date:	Daytime Telephone Number: ( )